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ABSTRACT

Parental involvement is critical to the maintenance and generalization of language behavior established in the instructional environment, in this case, a day training center for the mentally retarded. This practicum project sought to teach parents from 46 families to work effectively in the area of communication with their severely/profoundly mentally retarded child, thereby promoting carryover to the home environment, and also sought to alleviate the parents' feelings of ignorance and helplessness in providing such educational therapy. The involvement of each family member in caregiving, physical activity, and educational programming for the pre-pubescent or adolescent handicapped child was assessed. As part of a multi-faceted program, two luncheon workshops were held and literature was prepared to train the home caregivers in using an interactive approach to communication which responded to the child's modes of communication during naturally occurring situations, such as mealtimes and playtimes. Evaluation of the program indicated that parents who participated in some aspect of the program were able to develop realistic communication goals at their child's individualized education program conference. Fourteen parents (87%) believed that parent meetings were a viable and necessary part of the day training experience. Forty-four references are listed; the appendixes include survey forms: the family involvement sheet; project feedback; and parent evaluation of the program. (JDD)

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PRACTICUM REPORT

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Center for the
Advancement of Education
Ed.D. Program

A Mealtime/Playtime Communication
Program for Severely and Profoundly
Retarded Children and Their Caregivers;
Project Feedback

by

Natalie R. Kreitzman

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A Mealtime/Playtime
Communication Program for Severely
and Profoundly Retarded Children
and Their Caregivers: Project Feedback

by

Natalie R. Kreitzman

Cluster XXI

A Practicum I Report Presented to the Ed.D Program
in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

1987

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This practicum took place as described.

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This practicum report was submitted by Natalie Kreitzman under the direction of the advisor listed below. It was submitted to the Ed.D Program in Early and Middle Childhood and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved:

6-28-87

Date of Final Approval of
Report

Polly W. Peterson, Ph.D.
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This practicum report could not have been written without the cooperation and support of the staff and parents of the Middlesex Day Training Center.

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ABSTRACT

A Mealtime/Playtime Communication Program for Severely and Profoundly Retarded Children and Their Caregivers: Project Feedback. Kreitzman, Natalie R., 1987: Practicum Report, Nova University, Ed. D. Program in Early and Middle Childhood.
Descriptors: Severe Mental Retardation/Self Care Skills/Nonverbal Communication/Communication Skills/Parent Participation/Parent Role/Parent Influence

This practicum was designed to teach parents and other caregivers to work effectively in the area of communication with the exceptional child. The primary goal was to promote carryover to the home environment, and to alleviate the parents' feelings of ignorance and helplessness when it came to providing such educational services. The aim was to refine the caregivers' observational skills so that they might identify the handicapped child's modes of communication during naturally occurring situations, such as mealtimes and playtimes. A second aim was to share techniques with the caregivers which were specifically designed to facilitate communication in the multi-handicapped youngster.

The writer administered a family involvement questionnaire to the caregivers; determined the family structures of the day training students and identified the amount of time devoted to caregiving, physical activity and educational programming in the home; planned and conducted 2 luncheon workshops for the parents and other interested parties in order to promote an interactive approach to communication; supervised the home program; and, developed and administered a rating scale to determine the worthiness of the workshops and other forms of home/school communication for the participants.

The results of the practicum were encouraging. Analysis of the data revealed that parents enjoyed learning about an interactive approach to communication and that they were willing to share key elements of the program with family members and significant others. From a practical standpoint, parents who participated in an aspect of the program became able to develop realistic communication goals at their child's IEP conference. Fourteen parents (87%) believed that parent meetings, such as those developed by the writer, are a viable and necessary part of the day training experience, and eleven (67%) believed that parents ought to become more involved with project activities.

CHAPTER I

INTRODUCTION

Description of Community

The writer is employed at a day training center for the mentally retarded. A day training center is a public education program operated by the Division of Developmental Disabilities in nearly every county of the state. It offers educational services, care, training, and therapy (occupational, speech, physical) to severely and profoundly retarded youngsters ages 3-21. A day training center enables children to remain with their families and to benefit from the varied resources of the community.

This particular day training center employs 6 full-time teachers, 1 full-time occupational therapist, 2 part-time physical therapists and 2 full-time speech-language pathologists. Paraprofessionals (known as technicians and aides) as well as a parent-trainer liaison, a center administrator, a center supervisor, and 2 full-time nurses are also employed at the center. A social worker visits 1 day a week. In addition, the center employs bus drivers who transport the children who reside in 13 different communities. The center's centralized location necessitates fatiguing travel for many.

This day training center is located in a well-traveled, industrial area of the state and is situated between a penal institution, a diagnostic center for troubled youth and convicted sexual offenders and a residential placement facility for the mentally retarded. Essentially the school is far removed from the educational and social mainstream. Thus far, the residents of the community have had little or no reason to familiarize themselves with what goes on at the center.

Occasionally, a few residents will attend a fund-raiser, such as a flea market or a bake sale. Although the center is regarded as an institution of learning (the children take part in pageants; workshops are presented to the caregivers on successful parenting), the children do not come into contact with their neighbors on a regular basis. The staff members feel that the community is uncertain as to the types of children the center serves and its affiliation with the surrounding institutions.

The youngsters at this facility are classified eligible for day training. Eligible for day training means a level of functioning profoundly below age expectations, whereby on a consistent basis, the pupil demonstrates an inability to understand and respond to

simple verbal or nonverbal communication, demonstrates an inability to make known basic wants and needs, and requires total personal care and supervision. In addition, such severely involved children, according to Sontag, Burke, and York (1976) may include those who aggress toward others, self-mutilate, ruminate, self-stimulate, do not walk, speak, hear or see, manifest durable and intense temper tantrums, manifest minimally controlled seizures, and/or have extremely brittle medical existences. Life-maintenance care may include: (1) tracheostomy care, (2) gastrostomy care, (3) tube feeding (gavage) for children with feeding disorders, (4) aspiration management of children who choke easily on their food, and (5) urinary and stool collection devices.

If these day training centers were not in existence, these youngsters would receive educational services in an institutional environment or private facility as most public schools are not equipped to handle them. Skarnulis (cited in Frankel and Smith, 1978) wrote that the early education of parents of the severely and profoundly retarded was on procedures required for institutional admission, rather than on ways to keep the family intact. Emphasis was on the negative rather than the positive. He reported that over 45 percent of the institutionalized clients he studied had been admitted to facilities

for the convenience or welfare of other family members. The parents of these institutionalized children sought admission for 1 or more of the following 4 reasons: needs of siblings; emotional or physical illness of 1 or both parents; need for special education services; and dogmatic pronouncements offering institutional admission as the only alternative.

The day training staff members are instructed to assist the parents in evaluating their problems and in dealing with them in the most normative manner possible. They work with the parents to bring all potentially helpful forces to bear so that the involved child can remain home with the family (Frankel & Smith, 1978).

Author's Work Setting and Role

The center provides services to 48 youngsters from 46 families. There are 29 white youngsters, 10 Hispanic youngsters, 7 black youngsters, 1 youngster who is the product of an interracial marriage, and 1 Indian youngster. There are new arrivals (youngsters who have been at the center for 1 year or less) as well as others who have been at the center for 6 years or more. Most of the children fall into the pre-pubescent/adolescent category. Youngsters are placed according to chronological

age and physical handicap. Therefore, there are a number of children in the classroom for older children whose mental ages are significantly lower than some of the new arrivals' mental ages. Most of the new arrivals have attended infant stimulation programs which were not widely available years ago. Ten years ago the severely and profoundly retarded youngsters received custodial care and little education.

There are 9 single-parent households, 4 foster care families and 33 youngsters who reside with both a mother and a father. A number of families have more than one afflicted youngster. Thirty-three of the children have siblings while 9 are only children. The 6 children who reside with surrogate parents do not have contact with their natural sibs.

The writer is one of 2 speech-language pathologists employed at the center. Both hold advanced degrees, are licensed to practice in the state and hold the Certificate of Clinical Competence from the American-Speech-Language-Hearing Association.

The speech-language pathologist is concerned with the acquisition, development, reception, production, and/or improvement of communication. The speech-language pathologist

identifies disorders of language (receptive and expressive), articulation, fluency, voice and hearing and develops appropriate therapy programs. She is also involved with oral-motor function/dysfunction as it relates to communication and feeding. At present this clinician provides direct therapy to 17 youngsters. The remaining youngsters are seen on a consultative basis. Moreover, she presents 2 inservice workshops to staff and distinguished visitors each year.

CHAPTER II

STUDY OF THE PROBLEM

An adolescent approaching young adulthood leaves his family to set out in the world. His departure from home leads to a job, perhaps college, and to a period of sexual and social experimentation. The next developmental milestone is usually marriage followed by parenthood. The birth of a child is a crucial milestone--husband and wife become father and mother, and couple becomes a family.

Parenthood involves many lifestyle adjustments. It often means increasing expenses by almost $1/3$ while reducing income by roughly $1/2$, limiting mobility and freedom and giving up leisure time. There is a reordering of priorities concerning gratification of one's own needs to those of the child (Williams & Stith, 1980).

With a decline in the extended family arrangement, the new mother must rely on child-rearing manuals written by leading psychologists and educators, instinct, and observation to guide her. These manuals list developmental norms which show approximately when certain behaviors should appear. Thus, it is through published charts and by direct observation of other parents that the new parents base their levels of expectation

and abilities for their child.

Learning that one's child is abnormal violates the expectancies for achievement that most parents hold for their children. This violation of expectancies places parents in danger of feeling incompetent and helpless. The child's handicap serves as a cue to parents that their expectations must be altered; however, it is often unclear as to how they should.

Garbarino (1977) suggests 2 factors which facilitate effective adaptation to the parental role, lack of which may set up conditions leading to neglect (emotional, physical, educational) of the special child. First there must be a clarity of expectations (what is expected of the child; what will be expected of the parent) as well as an acceptance of the child for the way he is. Secondly, there must be willingness to make changes in one's lifestyle to accommodate the needs of the involved youngster (restructuring of time and finances).

Rather than focusing on positive expectations, the parents may become overly preoccupied with aspects on how their children are different causing them to become indifferent towards them.

Affective bonds between parent and child are

extremely important to early learning. The child's identification with attitudes and values of his parents is much more likely to occur than identification with attitudes and values of others (Berger & Fowlkes, 1980). But environmental conditions, limited ability or lack of reliable information often makes it impossible for the parents of an exceptional child to accept the very role that they most desire to fill, that of helping their child grow to his potential.

The key word in the education of the severely and profoundly retarded child is home. Articles treating the topic of educating parents or parent surrogates on how to live with the mentally handicapped persons in the larger community are outnumbered more than 20 to 1 by articles written on ways to train the retarded client directly while he or she is living in an institution. There is an emphasis on creating a variety of service models which can be administered specifically to maintain the child in his or her own home (Frankel & Smith, 1978).

A day training center's program has little effect on the child if it is not planned in conjunction with the home environment. Turnbull (1978) suggests a number

of reasons why parents should be encouraged to serve as trainers of their handicapped children. The more parents are involved with their children's training, the more likely is the children's functioning to generalize to other settings. Parents are powerful reinforcing agents. Parents know their children better than others, and generally spend more time with them than do professionals. Finally, parents receive gratification from contributing to the development of their child.

Hence, an increased and coordinated effort between parents and program was thought to facilitate social, emotional and cognitive development in the child. A parent should have been feeling strongly enough about his child's welfare that he should have been providing opportunities for the child to grow and allow him to accept responsibility for his own behavior. A problem existed when the parents' involvement in the program was not as extensive as the educational staff (in this case, specifically the speech-language pathologists) would have liked it to be.

Problem Description

Youngsters have been involved in a total speech therapy program. They have been exposed to educational techniques in the therapy session (which have been carried

over to the classroom) which had been proven to facilitate feeding and communication in the severely and profoundly retarded population. Parents had been invited to meetings and conferences, whereby the specialists demonstrated such techniques and explained the behavioral objectives behind them. The clinicians had even offered to go to the home in order to review the techniques. Parents should have been using those techniques being practiced in the school in the home environment. However, they had been reluctant to utilize the same educational techniques in the home environment for a number of different reasons. Many of the parents of the day training youngsters had been adverse to and/or frightened of educational techniques which have been used in the school by the speech-language pathologist.

If the problem had been alleviated, those educational activities designed and implemented by the speech-language pathologist would not have been seen as being conducted in vain. Parent and therapist would have been functioning as an effective team which would work for the betterment of the exceptional child. There would have been a degree of carryover in the home. The role of the speech-language pathologist would have been defined for the parent. The parent would not have been vague as to the responsibilities

of the speech-language pathologist as they relate to his or her child. The youngster would have been receiving many more opportunities to practice a skill and might have eventually responded in a more positive manner. The problem was the parents did not utilize or did not feel comfortable utilizing those techniques/exercises employed by the speech-language pathologist in the day training center in the home environment.

Problem Documentation

A binder is kept on each youngster at the day training center. The binder contains up-to-date medical reports, IEP conference notes, educational progress sheets, social service information, psychological reports and parental phone contact sheets. Staff members familiarize themselves with the information contained in each child's binder so that they can get a total picture of the child and his relationship with specialists and significant others.

The writer reviewed each client's binder and was able to make some very general statements. Most often either only 1 parent or no parent attended the scheduled IEP conference due to conflicting social or occupational obligations. Hence, the parent did not always help develop his child's educational goals. The parents did

not always call to say that they were not able to attend the meeting, nor did they suggest a more convenient time. Parents dropped in for other reasons and then signed the IEP. Most often the female parent attended the meeting; therefore, the staff members had very little contact with the male significant other in the family other than during a crisis situation. Occasionally older siblings attended the IEP conference, but did not participate, per se. In other words, they did not offer suggestions or criticisms.

Parents appeared resistive to carrying out, for example, dysphagia (swallowing) therapy techniques in the home. The child (although there has been a discrepancy between chronological age and mental age) was still receiving a bottle or baby food at home. The parents did consent at the IEP conference to having the clinician demonstrate language techniques in the home environment, but oftentimes, for one reason or another, the meeting was never held much to the dismay of the staff member involved.

Social service reports revealed, although gracious and pleasant in the company of the social worker, the parents gave the impression they would much prefer to be left alone. One particular report explained, "This parent does not seem very interested in following through with the program and seems to use the doctor as an excuse

for things she doesn't want to do." Other parents chose to hide behind their native language when it came time for educational planning meetings which have gone hand-in-hand with the program.

Moreover, one psychological report stated that the parent was annoyed that the child used diapering time as a time for play. Another did not allow her child to crawl into the kitchen when she was cooking dinner as he "got in her way." Those parents were not making use of teachable moments, that is, unplanned opportunities for learning.

Hence, it could be said that when the parents did not make a concerted effort to become involved in the program, the children suffered and the staff members silently vowed they would not make further attempts to intervene.

Causative Analysis

Parents were reluctant to utilize the same educational techniques in the home environment for a number of different reasons. Five are now addressed.

The children had not performed consistently. What was seen in the school setting was very often not seen in the home. The child's performance in the home was not consistent with his performance at school.

The school has provided the youngsters with a reactive environment. They have been provided with an

environment that they can comprehend and control just as non-handicapped children have done. The staff member has not anticipated the child's every needs. Unless the child has become actively involved in performing behaviors to get his needs met, he probably will never develop the full understanding, strength, or motivation to care independently for his own needs. The staff members have assisted the child to complete certain responses, then have gradually withdrawn (faded) their efforts. They have provided the child with continuous opportunities (while being dressed, while eating, being toileted or while playing) to develop these needs and to solve problems.

Contingent behaviors have involved the caregiver's (intervenor's) ability to read accurately and respond to the child's signals and communications (Greenspan & Lieberman, 1980). Contingent responses by the caregivers, that is, selective reactions to cues from the mentally retarded child, have helped him to consolidate initial causal schemes and distinguish means from ends in interpersonal relationships. For example, when the child smiles and the mother smiles as a consequence, the involved child has related his smile to that of his mother's. Similarly when the child reaches his hand out and his mother has countered

either by reaching out her hand or by some other affective or motoric response, or when the child has evidenced behavior consistent with being physically hungry and has been fed, or shows emotional hunger and has been held, he has begun to relate his means to these ends. After a while, the child has learned that if he makes certain noises, gestures, and/or affects, there is a strong likelihood that he will be cuddled, talked to or fed (Goldberg, 1977). Thus, parents and child make noises, look, laugh, talk, move, touch--all in a variety of ways. Such interactions have encouraged attachment between the parent and the child.

A staff member has usually been there to receive the child's attempts at communication and has responded sensitively and effectively. Often the staff member has taken the time to read the afflicted child's behaviors. Readability has been defined as the extent to which a child's behaviors are clearly defined and provide distinctive signals and cues for adults. In practical terms, readability has referred to the ease with which adults can say, "he is hungry, tired, looking at me," etc. A child who has been easily read enhances adult feelings of efficacy: (a) because they've easily recognized states and signals; (b) because decisions about interventions have been facilitated; and (c) because

there has been a high probability the adults would decide upon appropriate interventions and produce desirable outcomes (Goldberg, 1977). The parent who has constantly been doing things for the afflicted child often has been doing so because she has not been capable of reading her child's complex signals. Parents will never learn to independently read their children until they become good observers of their behavior. According to Mittler (1976), whenever two organisms meet, their reciprocal gestures must be mutually synchronized and balanced in a most delicate way before communication can occur. Communication can only develop in relation to others, i.e., in a social context. Communication encompasses all behavior generally used for the transfer of information between a sender and a receiver. A severely physically impaired cerebral palsied client with mental retardation may not have sufficient control of the oral musculature or the cognitive ability to produce purposeful speech; however, he is able to communicate. The pragmatic approach to communication takes into consideration the precursors of language, namely any gestural, vocal (prosodic sound strings), or facial-body responses used to control another's behavior or convey information. These aspects of phonation--prosody, body language, and gesture--for example, are sometimes

called paralinguistic features, yet, if one considers the total speech act, they are true linguistic features (Berry, 1980).

The child not only tries to understand the intention of the speaker, he also wants to express his intention to respond. In the plan of situational or pragmatic language teaching, communicative intention was essential to its success.

A disordered environment does not engage the child in a reciprocal manner. While contingent behaviors involve the ability to read accurately, anticontingent behaviors by the caregiver are those that are contradictory to the intended goal of the child's behaviors and signals as interpreted by the observer. For example, the mother moves away when the child seeks physical contact via the use of a paralinguistic feature. The child may express an interest in food preparation by crawling into the kitchen and by using using a paralinguistic feature and the parent reacts in a scolding manner. Noncontingent behaviors are those that are addressed to the child but are in no way tailored to his concurrent signals or communications. For instance, the semi-ambulatory child may be crawling after a toy and the caregiver tries to attract his attention by speaking to him. A child who gets no response or an inappropriate response to his cues (paralinguistic

features) may mobilize negativistic responses to achieve a reaction from the environment or eventually stop trying. The child may cry, whine, develop self-injurious and aggressive behaviors and in turn create feelings of ineffectiveness or helplessness on the part of the parent or other caregiver (Greenspan & Lourie, 1981). These paralinguistic features may gradually evolve into more complex forms of communication, such as single words or word strings. Language is a form of communication based on a referential or presentational system. That is, language is a formal system that uses symbols, generally words, to stand for objects, people, and events (Bloom & Lahey, 1978). Communication is based on a developmental approach: difficult skills are built on simpler skills. The behavior is acquired in a developmental pattern in which the simpler skills are modified into more complex ones. Language problems have arisen, in part, because the child has failed to develop the necessary foundation for acquisition of representational behavior. Van Dijk (cited in Robinson, 1975) states that it is impossible for a child to acquire language without passing through the stage of natural gestures.

To reiterate, the caregivers in the client's environment may have been anticipating the client's needs or may have quickly interpreted gross movements

or sounds without discriminating the actual intention of the client's attempt at communication. Misinterpretation of these attempts could have been devastating to a vocal client or to one who has been using limited vocalizations. Bigge (cited in Snell, 1983) discusses a way to avoid or lessen "deadlock" situations where the message giver and message receiver find their attempts at communication lost. Empathy conveyed in a statement like, "I don't understand what you mean. It sure makes me feel sad. Let's try again," may have helped the client continue to try.

The profoundly handicapped child does not always initiate interaction and does not respond quickly, and sometimes responds not at all. Since no one talks to or has "answered" the child-tender, he has become bored with the monologue and begins to think about something else. If the child is passive (hypoactive) and a weak sender, the mother, father, sibs, baby sitter or other interested party could be taught to read these otherwise difficult signals and to work with the child toward increasing the strength of his signals. For example, if the child only put his hand forth very slowly in order to make contact, he could have been met by the intervenors $3/4$ s of the way.

A second cause behind decreased parental involvement in educational programming was an unfortunate lack of communication between parent and the school.

The speech-language pathologist was unsure of what transpired educationally after school hours. Many of the parents discussed their child's educational planning only once a year at the IEP meeting. The staff members had a tendency to "come down hard" on parents who were infrequent visitors to the school. The parent often felt pressured to say that indeed such and such a technique was being utilized in the home at the IEP meetings, which might not have been the case at all. Often the speech-language pathologist found this out in the therapy session when the youngster was not making gains in, for example, dysphagia therapy, which required a certain amount of carryover at mealtimes.

The next cause behind this problem was that parents were overwhelmed with financial, emotional and marital difficulties and care of siblings to concern themselves with direct educational intervention. The parents must tend to the 24 hour child. The 24 hour child is someone who needs care 24 hours a day. He needs direct help with all of his personal needs and activities of daily living. Expediency is and has been the key word. They want to complete a self-help task, such as toileting, bathing or feeding in the least amount of time. Contextual variables often play a part. For example, motor activity may be

desirable when the dyad is engaged in social play or free associations, but undesirable during diaper changes. The intervenor should make listening enjoyable for the child by talking about ongoing situations and actions that the child can see. To facilitate learning, explains Michaelis (1978), language must occur at a time significant to the child, such as feeding, being changed, or being held, for the child to single out a sound or gesture worth remembering. Repetition of the same linguistically appropriate models in various physical locations but with the same meaning is crucial to more generalized learning. The profoundly handicapped child needs someone who cares enough about him to talk to him about his spinach, coat and "pee-pee" at the appropriate times.

Bricker and Casuso (1979) list light tickling as a suggested procedure that is physically stimulating to the client and which may evoke vocalizations which can be imitated by the intervenor and for which the client can be reinforced. Thus, even a messy job like diapering could be considered practice time for communication if it was combined with verbal messages, such as, "Oh, you have a dirty diaper," or "Now, I'm tickling your tummy," and tactile stimulation. Messages can be further shortened

to "Dirty diaper?" or "Tickle tummy?" as the situation demands.

A further cause was that parents did not feel capable of providing an educational program in the home. Some of the parents are foreigners who do not have a good command of the English language. Moreover, they felt they were not capable as they were not degreed personnel. The assumption has been that only professionals have the wisdom to make sage decisions about other persons' destinies. This is known as professional omnipotence (Roos, 1963). Many parents have viewed the therapist capable of initiating a near total cure (miracle worker) for their child's problems rather than realistically seen this professional as a guide and parental advisor regarding their child's development. Further as they are not master's degreed professionals, they have believed that they have little to offer their child other than custodial care. The professional's use of jargon (medical terms, etc.) has fed into parental inadequacies. It is important at this juncture to define what is meant by a "teacher." A "teacher" is not someone who inevitably knows all the right answers, instills knowledge or even motivates the child to learn. Rather, a teacher is someone who responds to the abilities, needs and

interests of the learner by providing real opportunities for learner-initiated activities that contribute to development (Schoenig, 1978).

The final cause behind this problem is that parents had deflated or inflated expectation levels for their afflicted child. These attitudes did not develop overnight. As previously mentioned, many of the clients are prepubescents and young adolescents. When these children were infants, the emphasis was on residential placement and custodial care rather than on infant stimulation or early intervention programming. Professionals were guilty of professional hopelessness. They would tell the parents that the child had an incurable condition and would never amount to anything (Roos, 1963). Hayden and McGinness (cited in St. Louis and Musselwhite, 1983) advocate early intervention with children at high risk for developmental disabilities. They assert that "failure to provide a stimulating early environment leads not only to a continuation of the developmental status quo, but to actual atrophy of sensory abilities and to developmental regression" (p. 153).

Moreover, a number of the parents of younger children believed that their children would "snap out" of the handicapping condition one day either because of the experts' interventions or because it was God's will. These parents

have not accepted that their children are retarded or physically limited. They felt and continue to feel that their children are just slow and will begin walking and talking any day.

Until recently, severely and profoundly handicapped persons were thought to be incapable of learning and that, consequently, the establishment of developmental programming for these individuals was considered futile. The tide has turned regarding education for the severely and profoundly retarded population. Education is to be provided to all children regardless of the handicapping condition. A number of educators have demonstrated that these individuals can learn to communicate (with the use of an aided or unaided augmentative communication system)--a skill that was not previously considered possible. However, each child must be seen as an individual possessing different strengths and limitations. In order to attain vocal language, at least 10 prognostic factors must be considered, such as, the client's physical ability to produce speech sounds; history of success within the communication situation; motivation; attention; the ability to imitate words verbally; adequate hearing and vision; and the age at which training

is initiated. One must remember that many of the older children were not involved in an infant stimulation program and that can make all the difference (Bloom & Lahey, 1978).

Professional omnipotence has played a large part in all of this. When the parental desires have not been realized, (child cannot speak even after many years of therapy with the speech-language pathologist), frustration and depression, as well as deflated levels of expectation (in all areas), and a lack of interest in parenting workshops presented by the specialists may have occurred on the part of the parents. The significant others needed to be shown that vocal language was only 1 form of communication when one does take the paralinguistic features into consideration. The severely and profoundly retarded children who have been attending a day training center are not incapable of learning. They have potential like any other youngster; and they are capable of communicating if they have an enlightened audience. Finally, Haring (1975), in discussing the potential of the severely handicapped, cogently remarked that a critical need exists to change any conceptual limitations placed upon future growth of the severely/profoundly handicapped. Their potential is practically unknown because effective intervention programs have not existed till recently.

The Related Literature

A review of the literature revealed that not too long ago parents were viewed as part of the problem, but due to the advent of Public Law 94-142 (mandating parent-school meetings at specific points in the child's special education placement and programming process) they are now part of the solution. Prior to PL 94-142, parents were given the deaf ear by professionals. Some professionals seemed unable to hear some of their clients' statements. Parents of a retarded child gained the impression that they were being perceived as complete ignoramuses, so that any suggestion they might have made regarding their own child was categorically ignored. This propensity on the part of some professionals to ignore parental suggestions or information might have resulted from their destructive stereotypes of parents, a stereotype which unfortunately still exists today. Parents must quell this stereotype by becoming involved in one or more of the 5 stages of educational intervention. They are identification, assessment, programming, implementation, and evaluation (Turnbull & Turnbull, 1982).

The parent involvement policies of PL 94-142 are

implemented in many different ways. Some educators perceive parent involvement as a choice; others see it as a requirement. The problem results when the distinction between parental involvement with the special child and parental involvement in the educational program for that same child is not made. It is felt that educators must defend the right of parents to choose not to be directly involved in the educational program when they believe that noninvolvement will be beneficial to them, their handicapped child or to the family. Otherwise a strain is created between parent and educator and lines of communication might break down completely. Baker (1976) points out that voluntary involvement of parents may be essential to the success of a home-based education program. When professionals make home visits for the purpose of instructing the parents in educational techniques, basic courtesy should be extended. The professionals should ask the parents in advance for permission to visit them at home, be prompt, listen attentively to the family's concerns when they might conflict with the purpose of the educational meeting, and respect the family's privacy. Many parents of handicapped children feel threatened by home visits and may believe that the visitor is evaluating their lifestyle or

standard of living. A drawback to home training often occurs when parents work during the day and are at home only in the evenings, or if the handicapped child is in school when the professional wants to demonstrate the child's proficiency in a skill to a parent who is home with young children during the way. When both parents have busy jobs (either running a household or a business) in which they interact with people the whole day, they might prefer "time-out" from professional interactions in the evening. Some families are large and must tolerate substandard living conditions. A variety of substandard living conditions have been shown to contribute to poor mental and physical status, including lack of hot water, poor temperature control, infestation of vermin, flaking lead-based paint and lack of safe outdoor play space. Poor homes lack many features which are standard in more advantaged homes, such as toys, crayons, books, records and one's own bed. Home is likely to be disorganized and chaotic. Disruptions can make it impossible to concentrate on training or to carry out a prescribed program. In these circumstances, the training might best be delivered in the same setting (at the school), in the form of a workshop (Snell, 1983).

Obviously not all families will be willing to train

their children at home. Many families gave up trying years ago when little progress was made. However, it is still the professional's (the speech-language pathologist's) responsibility to insure that all parents are familiar with the training goals (through the use of telephone calls, mailgrams, and descriptive literature) and the student's progress towards them. The clinician can describe situations in which it might be appropriate for the child to use the skill being trained, and encourage the parent to participate to some degree in the child's educational progress.

According to Turnbull and Turnbull (1982), society's fundamental misconception is its view of the handicapped as perpetual patients with a need to get well for they are unacceptable the way they are. For example, the child must use vocal language as it is the "normal" way of communicating. The child is truly "less than adequate" if he resorts to paralinguistic features to make his needs and wants known. The need for parents to be teachers of their children day-in and day-out; year-in and year-out to help their children "get well" is unrealistic and not what educational involvement is all about. Children often become objects of remediation rather than persons with whom education can be enjoyable (Linder, 1982).

According to the literature, parents can play 3 key roles: parent as parent/caregiver; parent as decision maker/advocate and/or parent as change-agent/teacher. Many demands are typically placed on parents just in the routine child care they must provide to their children. Being "just" a caregiver is a full-time occupation. The impact of these activities (feeding, handling, toileting, bathing) may have a variety of effects on the mother-child interactions, maternal self-concept and the degree of stress on the family unit. Many of the children are in "delicate health" necessitating frequent visits to medical personnel.

Other parents may opt for the role of decision maker/advocate. Parents want to be involved in education decision making and when given the opportunity will take advantage of it. However, many parents apparently prefer a role of receiving and confirming information at the IEP meeting, not one of active and assertive contribution (Porcella, 1980). They often prefer to be the secondary treatment giver. Goldstein and Turnbull (1982) found that the majority of parent contributions in the IEP meetings were on the topic of personal/familial issues not on such educational issues as evaluation, curriculum and placement. Expecting all parents to be equal participants

in decision making is setting up many--if not most--parents to fail and many educators to be disillusioned by parents who do not fulfill this awesome and sometimes unwelcome responsibility.

Parent participation in program and priority planning sessions (parent adopts the role of change agent/teacher) not only allows for increase in trust between the professional and the parent, but also assured parental carry-over at home.

According to the literature, it has been estimated that over 1 million children in the United States are unable to communicate orally due to severe physical or linguistic limitations. Hence, the speech-language pathologist is faced with the task of developing strategies to enhance communication effectiveness in order to facilitate language learning and social interaction (Russel, 1984). An augmentative system is one which enhances a person's present means of communication. The severely and profoundly retarded youngster relies heavily on gestures and other physical kinesics to carry a message to a listener. This communication system is limited because it is functional only between the child and those who know the gestural system, such as the teacher, the speech-language pathologist, the baby sitter, and the parent. However, many parents do not

realize or expect their child to be able to communicate their needs so they provide the child with a stimulus such as a foodstuff without requiring a response. The augmentative system should be viewed as a tool which must be nurtured in a reactive environment for it promotes and facilitates other, more advanced communication modes.

The degree of parental involvement is critical to the maintenance and generalization of language behavior established in an instructional environment. Changes in behavior that are limited to the instructional environment alone have little long-range benefits for the children (Wulz, Hall & Klein, 1983). Lovaas (cited in Villani, 1980) states that educational treatment of the developmentally delayed child without parental training in similar educational procedures and counseling can result in limited or transient effects for the child. There is evidence that shows that parents can successfully teach their handicapped children pre-linguistic/ language skills. Furthermore, very little professional investment is necessary to teach parents to help their children. Interactive training, rather than formal training, appears to be a more effective and promising educational route. Interactive training, otherwise known as incidental language training (Gerber-Wollner, 1986), is conducted

during those situations that normally arise during the day where the child has an intent or need to communicate (a teachable moment). The specific stages in each new interaction with the environment include: the child will resist the interaction; tolerate the interaction co-actively with the intervenor; co-operate passively with the intervenor; enjoy the activity because of the intervenor; respond co-operatively with the intervenor; lead the intervenor through the activity once the initial communication has been given; imitate the action of the intervenor upon request, and initiate the action independently. Whenever an activity is discussed (whether it be vocal imitation, verbal imitation; visually orienting to a spoon; localization to human voice or to gross sounds; manipulating an item, be it a utensil or play thing) the following steps are stressed: the child must be alerted to the intervenor's presence (hypoactive or sensory impaired youngsters might require a gross sign, or light physical prompt, such as a touch or a pat); the intervenor must alert the child to the coming activity (using basic language, the intervenor must make sure the child is looking at his environment); the intervenor must introduce the activity (by sign, verbal description, demonstration, and manipulation, he must explain to the child exactly what he (the intervenor

is going to do and the choices which are available to him; the intervenor must encourage the child to do it; and lastly must review what the child has accomplished (McInnes & Treffry, 1982).

Artificial reinforcers, such as candy or tokens, do not operate as discriminative stimuli for the response, that is, they do not signal the child that he or she will now be reinforced for responding. Thus, there is the unlikelihood of generalization to new situations.

A program which utilizes an interactive approach to language teaching is the Infant-Fold program offered at the Syracuse University Children's Center. In this program, the parent participates in the classroom on a regular basis while each special youngster is assigned to a particular caregiver/instructor who is the person primarily responsible for her or his feeding, comforting, learning games, language experiences and loving. The parent is encouraged to watch the caregiver as she works with the child. A prominent philosophy of the Infant-Fold program is that language and learning experiences should be integrated into daily routines such as diapering, bathing and feeding. Such integration is in line with the belief that cognitive and social

development can not be separated in infancy and is also in line with the Piagetian viewpoint that activities form the basis for sensorimotor-period learning. Additionally a significant salutary effect of this type of program is the enhanced social interaction patterns that may occur between the parents and the disabled child. Such outcomes may include the establishment of a foundation for later communicative ability, the cultivation of the rudiments of language and the development of the precursors of the speaker-listener roles (Schell, 1981).

An experiment which offers information about communication of youngsters with minimal language acquisition following systematic observation of real-life situations was conducted by Berry and Marshall in 1978. The interactions of 4 mentally retarded children with comparable language-ability levels were videotaped under 6 separate conditions for 5 minutes for each condition. The conditions were free play with (a) one toy, (b) 3 toys, (c) 6 toys and d, e, and f were the same as a, b, and c except that a qualified preschool teacher, referred to as the facilitator, was present.

The videotape was set permanently in position so as to cover as much of the room as possible.

Interactions included (a) verbal interactions (occurring when actual language was used); (b) nonverbal interactions (involving only nonverbal behavior, e.g., smiling); (c) physical interactions (body-contact not involving language, e.g., pushing away). Results showed that when the facilitator was present, there were more social interactions and vocalizations, but there was no significant increase in meaningful verbal content. Nonverbal communication rose sharply in the presence of the facilitator. The findings indicate that an observational analysis of patterns of interaction is useful in planning intervention programs in the area of social and communication development in the retarded. Moreover, the parent or significant other can be used in the position of facilitator.

In a study conducted by Lombardino and Mangan (1983), 6 developmentally delayed children and their parents participated in an intervention program designed to promote receptive and expressive language. The children ranged in chronological age from 1-4 years and formed a heterogeneous group with respect to diagnosis descriptions. Parents were taught to plan and implement not only structured teaching sessions but also to stimulate language development in free play interactions with their child at home. Within the context of free play, parents were taught 5 language stimulation techniques which have been identified

as facilitative to language development. They are naming, referencing, imitating, expanding and parallel talking. The parents were videotaped 4 times throughout the program. Parents' use of selected language stimulation strategies was determined from pre- and posttest videotaped 5 minute free play interactions. A descriptive analysis of each child's prelinguistic and/or early linguistic communication skills was completed pre-and post-intervention. As a group, the children mastered approximately 64% of all items trained at home. Criterion for mastery was correct performance on 3 consecutive training days.

In a study conducted by Koenig and Mervis (1984) interactions of prelinguistic severely handicapped children and their caregivers were compared to the interactions of prelinguistic normal children and their mothers. Comparisons were made with regard to the children's use of gestures, patterns of play, and natural opportunities for developmentally appropriate communicative stimulation. Overall, no significant differences were found between the children's use of prelinguistic gestures or their patterns of play.

However, results indicated that the severely handicapped children's linguistic environments differed significantly from those of the normal children. The severely handicapped children were provided with significantly fewer opportunities to hear labels for the objects of their attention and to observe functional object demonstrations, an experience found to encourage the onset of referential language or the use of object-oriented gestures.

From a sociological viewpoint, just as educational strategies, programs, and environments differ so can family forms. Each type of family form is suited to a specific instructional mode. In the nuclear family network, husband, wife and offspring live together in a common family. In a traditional environment, the husband is the "breadwinner" and the wife is the home manager and the child rearer. This environment most often leads to a mother/exceptional child dyad. In a modern environment, the father may stay home while the wife is employed on the outside. This leads to a father/exceptional child dyad.

According to Lamb (cited in Williams and Stith, 1980), fathering and mothering are different, each unique and qualitatively different, and both girls and boys seem to profit from contact with both parents who meet different

growth needs. Pederson, also cited in Williams and Stith, suggests the father exerts both direct effects and effects mediated by the mother. The father's interaction is different from that of the mother; there is more rough housing, active arousing play which can lead to increased vocalizing, more limited contact than the mother which enhances novelty value, interaction more tied to play than to meeting physical needs; therefore, it forms one of the bridges to the larger environment, particularly for the involved child. In addition, support of the husband to the wife seems to add to her effectiveness in mothering.

Financial difficulties stemming from medical care, prosthetic devices, hiring outside assistance in child management may lead to an androgynous household. Parental and other household and work responsibilities are shared by the husband and wife. This often leads to a mother + father + involved child (+ or - sibling) educational set-up. This is known as a nuclear family network. The goal is to involve as many family members as possible in the caregiving and stimulating roles. By increasing the number of family members who interact with the exceptional child, the family achieves integration of the child into the family unit, allowing attitudes and roles to become more normalized. The goal is to make

the child/family interaction pleasant and relaxed.

In a single-parent family either man or woman (more often woman) and one or more children may live together as a result of death of spouse, divorce, separation, abandonment, or non-marriage. In 1985, 23% of the 62.5 million children under the age of 18 were living in single-parent homes. In 90% of the single-parent homes, the parent was the mother. Fifty-four percent of the nation's black children, 29% of its Latino children and 18% of its white children lived with only 1 parent (Shearer, 1987).

A 3-generational or extended family consists of 3 generations in a single household (parent, grown child and grandchildren). This arrangement leads to an extended family network whereby the grown child, siblings and aged parent(s) contribute to the education of the afflicted child.

The next family form is the adoptive parent or foster parent family. Involved children absent from natural parents are placed with a parent/parents who are well endowed for the job and well matched to their prospective charge. Foster parent, adoptive parent families are suited to a mother + father + involved child triad, assuming there are 2 parents in the household. Only about a third of the children who are labeled behaviorally disordered are living with their original, intact parents (Kroth, 1985).

From a psychological perspective, there might be stress from within the family unit which results in episodes or crises of varying degrees of severity which precipitate the expression of that family's need for assistance of a different nature. The birth of another child, especially if the family is already large, where outside support is not readily available, where the child may also be mentally or physically damaged or where there have been several children born in rapid sequence may lead to excessive levels of stress. Marital friction ranging from strife to separation and impending divorce will also affect the emotional state and stability of the family unit. Illness, mental or physical, on the part of other members of the family is also an important factor to consider. Interference or lack of understanding and support on the part of significant members of the greater family; demands and needs of siblings--ranging from learning to live with a handicapped sibling to sibling rivalry of varying degrees of intensity; or social isolation, exhaustion or frustration resulting from actual or self-imposed family demands all interfere with the handicapped child's educational and emotional progress outside of the school environment

The afflicted child is very often a member of a "multiproblem" family, whose parents are all too often children themselves, unable to assume the responsibility of raising an exceptional child. Parents are generally assumed to be the significant ones who monitor, regulate, and govern the environment in which their child develops (Barnard & Erickson, 1976) . Knowledge of child rearing, home management and coping in general is not sufficient to allow the inexperienced parents to be totally effective. It is especially difficult to know how to rear a normal child let alone a multi-handicapped child. The lack of adapted behavior development and the development of severe maladaptive behavior in some profoundly retarded persons can be a function, in part, of the poor learning environments in which they are raised (i.e. sterile home environment). Many of these children are left in front of the TV set. Very often they will resort to self-stimulating behaviors in order to amuse themselves. In many families, the passive and conforming child is valued. In addition to being mentally retarded, children who are unconforming, irritable and difficult to manage may suffer physical abuse at the hands of parents pushed beyond endurance. T here is

evidence; however, that passive children tend to further decline in intelligence as they grow older (Robinson, 1976).

Horner (1980) studied the influence of environmental stimuli on the behaviors of profoundly retarded individuals who were nonverbal and did not respond to verbal commands. The results indicated in an enriched environment, whereby certain stimuli, particularly (inexpensive) novel items (brightly colored objects) were available, there were greater outer-directed (responses toward the environment) than self-directed (manipulation of own body and stereotyped movements) behaviors exhibited than when these stimuli were absent. Based on the data cited, it appears the profoundly retarded individuals learn from their environment and that much of their lack of learning appropriate behaviors and/or development of inappropriate behaviors can be attributed in part to a sterile, austere environment. Hence, there is the need to educate parents accordingly.

To summarize, becoming an effective teacher of one's own child is a formidable undertaking and certainly not appropriate for all parents if one examines all components of the issue.

The parental competencies required for direct teaching of the handicapped child at home involve interacting with the child in ways that

promote positive behavior; reinforcing desired behavior; establishing an environment that is conducive to learning; setting up and maintaining a routine for direct teaching; using procedures appropriate for teaching concepts and skills; determining whether the child has mastered knowledge and skills; keeping meaningful records, including notes on child's progress; communicating effectively with others; and assessing the child's stage of development (Turnbull & Turnbull, p. 119, 1982).

The implication is clear; to be a good parent, one must have skills comparable to a master's level special educator, and still have time for IEP participation, self-fulfillment, individual and system advocacy, employment and other family responsibilities.

Sondra Diamond (1981), a psychologist who is physically disabled, made an attempt to comment on the needs of her parents.

My parents as individual people were constantly asking themselves, 'Which is more important at the moment, my disabled child's need, my need, or my

spouse's need?' What are the effects of these conflicts on each parent, on the marriage, and on the disabled child? The potential effects are myriad: confused adults, an alienated couple, and an egocentric child, to name just a few. People have limited amount of psychic energy. . . If we are forced to juggle this psychic energy for a sustained length of time in such a way as to spread it around 'equitably' (between self, spouse and the child), we feel frustrated, exhausted and ultimately confused. In this fog-like state, disintegration takes place; disintegration of one's own personality and disintegration of interpersonal relationships. To avoid this bleak forecast it is imperative that a parent of a disabled child finds a comfortable level at which to function (p. 29).

Research shows that the kind of home programming likely to be successful is one which is easy to run, fits into the routine of the day, has been modeled clearly and practiced by the parent during a training session, has been suggested repeatedly by the parent, and finally, is reinforced by the school

staff, both verbally and by being taught in the classroom. Programs which are usually doomed to failure are those which are fairly difficult to operate, time-consuming, suggested by the teacher or other staff member and reluctantly accepted by the parent, and those which are implemented in the home and never monitored or reinforced by staff members (Porcella, 1980).

Beneficial effects for the parent include enjoying the experience, increased understanding of the educational program, learning things that enable the parent to work more effectively with the child, emotional support, enhanced self-esteem because of meaningful contributions, and a feeling of "belonging" that is satisfying to the parent. Detrimental effects might include frustration, absenteeism from work, time away from other children, decreased leisure time, physical exhaustion, the feeling that one is doing things one should not have to do, or emotional dependence on the program staff (MacMillan & Turnbull, 1983).

The fact remains that the involved child is the parents' responsibility as long as they live. They can choose to grieve through the rest of their

lives (chronic sorrow) or they can pass through the psychological stages of denial, bargaining, anger and depression and begin to accept their child's condition and climb the productive steps of habilitation. Research shows that parental involvement in the child's educational program begins to reduce helplessness (parents come into contact with other parents who share similar problems) and promote feelings of competence, effectiveness, playfulness and spontaneity in all family members and independence in the afflicted child (MacMillan & Turnbull, 1983).

From a practical viewpoint, although most parents prefer to rely on the "experts" to provide training, parent participation in therapeutic intervention programs may be the answer to dwindling financial resources in the social and habilitative services which limit the amount of time therapists can offer services. Therapists are often available only 2 days per week. Hence the child receives attention from the therapists only 2 days per week or less (if the caseload is exceptionally large). However, if the parent is trained to provide services in the home environment, the child will be receiving "therapy" 7 days per week.

CHAPTER III

ANTICIPATED OUTCOMES, AND EVALUATION INSTRUMENTS

Statement of General Goals

The goal of an educational program is to teach parents and hopefully other family members specific interventional skills with the realization that the other family needs must often be met before parents are able to learn to apply educational intervention strategies. The family situation itself dictates where, when, how and in what areas intervention is begun. To reiterate, many of the families are needy and require social service intervention. Locating housing or financial assistance for a family may be as critical to the child's educational progress as is her or his individualized plan. A sibling who resents the inappropriate attention given the handicapped child can be trained to teach his special brother or sister fine and grossmotor games and self-help tasks. This should increase the siblings' pride, competence, and their feelings of importance in the family as well as facilitate the handicapped child's development. In a family where grandparents have denigrated the parenting skills of the child's

parents, a task is devised so that parents can shape or control some child behavior that the grandparents have been unable to influence. The parents' competence is thus demonstrated, and the family can restructure itself accordingly so that the parents have the major responsibility for the care of the involved child.

The general goals were to teach parents to work effectively in the area of communication with their exceptional child, thereby promoting carryover to the home environment, and to alleviate the parents' feelings of ignorance and helplessness when it came to providing such educational services.

Behavioral Expectations

The following specific behavioral objectives were projected for this practicum: the writer would study the family structure of the day training youngsters (the clinician would review the information contained on a family involvement questionnaire which would be completed by a member of the family and returned to the center) and would identify one or more feasible educational modalities from the information contained therein; the writer would develop literature which would be disseminated to the Hispanic and English-speaking parents; following

workshop/newsletter presentations, the interested parties as a group would be called upon to formulate 1 or more realistic communication goals (written) for the future; following workshop/newsletter presentations, the interested parties would comprehend what was meant by a pragmatic approach to communication (Gerber-Wollner, 1986) and would develop their observational skills by identifying (in writing) on the Project Feedback Communication List their child's intentions used spontaneously and during teaching assignments. The child's intentions would be defined as his social interactions of anger, pleasure, approval or indifference, his bodily movements, and gestures and facial expressions; and following workshop/newsletter presentations, the parents would familiarize themselves (take the literature home and read it) with and/or utilize (for a period of 1 month) an interactive teaching approach to communication in a natural reactive setting (at mealtimes, playtime, bathtime, dressing time) or at some other time suggested by the parents.

Evaluation Instruments

The Family Involvement Sheet (FIS) was a written instrument which was sent home with each child. It contained questions directed at family structure and

the amounts of time devoted to caregiving, physical activity and educational activity. It was developed so that the clinician could determine who worked with the child and the strategies employed. It contained a section asking the families if they would attend one or both meetings (a RSVP). The questions were closed. A cover letter, which introduced the instrument and announced the deadline, was attached to the questionnaire. A follow-up postcard was mailed out as a reminder. Those who did not respond received a personal telephone call from the writer after the deadline.

At the close of the workshops, it was anticipated that the presenter would ask general questions as a means of gaging whether the family members understood the key elements of an interactive approach to communication as it relates to the special child, and to ascertain whether the speaker was effective in explaining such an approach in detail, and whether or not the parent and/or other family members, baby sitter, aunt, uncle, grandparents, sisters, brothers would be willing to adopt such a program in the home for a period of 1 month.

It was anticipated that the writer would compare the results of prior educational involvement and its importance to the whole family (by looking at the results

of the Family Involvement Sheet), to anticipated involvement at the end of the 2 workshops on communication, and the place of educational programming and its importance to the family at the end of the 1-month trial periods. The Parents as Resources worksheet (PAR) would be given to the family members at the end of both 1-month trial periods. The PAR is a rating scale consisting of 15 questions on parental involvement. By looking at the completed PARs, the clinician would be able to surmise if meetings had been deemed worthwhile, to date. It would be assumed that if meetings had been deemed worthwhile, that specific elements of the meetings would be incorporated naturally into the home environment. If the majority would consider meetings and other modes of learning as they relate to the handicapped child beneficial, then essentially, the objectives of this practicum would be met. Previous educational commitment by day training parents (a willingness to attend IEP meetings and give input; a willingness to attend other educational conferences and to use techniques learned at said meetings in the home) has been wanting.

CHAPTER IV

SOLUTION' STRATEGY

Discussion and Evaluation of Solutions

The issue of parent involvement in the education of handicapped children has received strong support in the past few years. A study conducted by Cohen (1977) represented an initial attempt to measure the attitudes of professionals towards parent participation. Forty-one special educators, the majority from programs for severely and multiply handicapped, responded to a s hort questionnaire designed to measure support or nonsupport for various types of parent involvement. Parent roles ranged from the very traditional home support for the school, to the emerging idea of a partnership between home and school. Opinions were solicited on using parents as trainers of other parents, using parents as teaching assistants in the classroom, and other parental roles within the educational process. Results of the study indicated strong support for parents as homework helpers. Those areas which were not endorsed as appropriate were the use of parents as teaching assistants in the classroom, and the use of parents as trainers of other parents.

The parents at this center have been involved in fundraising events which are held to raise money for the day training facility. The parents have not had the time to be involved in extensive training programs which stress parent-teacher partnership in the classroom as they work outside the home or tend to young children. The level of interest and commitment needed for this type of program just has not been there, yet this doesn't mean that the parents do not care about their children or want them to attain their maximum potential, however great or limited that potential may be. A major portion of the therapeutic attention must be directed toward helping parents see that they can participate in the educational development of the children at the level most comfortable for them. The strongest source of motivation to encourage parents to interact and teach their handicapped children is to be found in the components of the interaction itself. It is unrealistic to expect parents to engage in positive productive interactions with their children without the reinforcement and satisfaction of knowing that what they do will definitely help their children

attain their maximum potential. Practically all individuals, both handicapped and non-handicapped alike, were taught language expression by non-professional persons, their mothers. Language is not a 45-minute lesson which relies heavily on pictures or objects to stimulate the responses (an artificial environment) rather language is an integral part of any interpersonal communication and is best learned by the severely and profoundly retarded youngster in the natural context of those daily interactions and facilitated by the teacher, aide, speech-language pathologist in the school and the parent, baby sitter, and/or other family member in the home. Communication is a distinctly human response. Unless caretakers see the child as a human being an interaction of feeling and language for feeling cannot be developed. Early child language is a language of feeling and of events, not a language of thought (Michaelis, 1978).

According to Wulz, Hall and Klein (1983), the Instructional Communication Strategy is a program which trains the parent to provide direct language training to the child during naturally occurring situations. In an incidental teaching program such as this, the environment is arranged to increase the likelihood

that the child will initiate to the adult and, thus, will provide incidences for teaching. In addition, the parent/caregiver must select language targets appropriate for the child's skill level, interest, and the opportunities the environment provides.

Roe (1986), a UCLA psychologist, studied the chatter patterns of 103 mother and child teams. She found that mothers who talk nonstop at their children may be inadvertently overstimulating their immature intellects. Roe recommends that parents talk to their youngsters for only 25 to 30 percent of the youngster's waking hours. In addition, Menyuk (1987) found that parents who supplied children with a steady stream of information were not necessarily helpful. Rather, language skills were more likely to develop when parents provided lots of opportunities for their children to "talk" and when parents listened and responded appropriately to their child's communications.

An incidental teaching approach teaches parents to respond to the child's initiations with requests for elaborated language resembling the targeted forms and to reinforce the child's communicative attempts as well as use of specific forms with attention and access to the objects in which the child has expressed an interest.

The Instructional Communication Strategy is a program which enables the speech-language pathologist to best utilize her skills for assessment, program development, monitoring progress, and training more advanced, specialized skills. The parents' unique relationship with their child and the natural communicative situations in the home maximize the effectiveness of direct training efforts.

Suzanne Evans Morris (1981) states that opportunities are often missed for incorporating improved oral movements into vocalizations and for improving communicative facial expressions or nonvocal gesture responses during feeding. The mealtime setting (a naturally occurring environment) can be used creatively to increase the positive interaction between the child and the caregiver and to establish the basic prerequisites for the development of communication.

Thus, the purpose of parent intervention should be to teach parents when it is appropriate to begin certain kinds of interactions, what interactions are appropriate to the developmental level of the child, and how the child will be influenced by the interaction (Michaelis, 1978).

Description of Selected Solutions

A program was designed to describe to parents, other interested parties, and to other family members of the day training youngsters the merits of an interactive approach to communication. The program was developed to help bridge the gap between the home environment and the school environment.

The writer was prepared to describe to parents/family members of the day training youngsters the home-based interactive approach to communication (which includes a section devoted to pragmatics, observational skills and to oral language) in detail at 2 afternoon meetings (to insure optimal parental participation) and in newsletter presentations.

The Project Feedback Communication List (PFCL) was an integral part of the program. Family members would be asked to take the sheet home and to utilize those observational skills as discussed at the meetings in the home. Family members would be required to check those communication behaviors that the child used spontaneously (at mealtimes and at playtimes) and those that occurred when a specific skill was being taught in a natural setting. The program was best suited to mealtimes because (a) the

environment was natural and consistent (each parent would be using similar materials in a fairly structured environment--these youngsters ultimately profit from structure rather than novelty); (b) the need to communicate was built in--the child could make an active choice in a reactive environment; (c) the situation lended itself to basic vocabulary words: one would be able to discuss the utensils involved, the smells, the tastes, the naturally-occurring environmental sounds (such as bacon sizzling, water running and a tea kettle whistling), and the many different colors and textures; (d) a great number of the children would need to rely on human assistance at mealtimes; and (e) repetition of skills would be guaranteed as each child would be fed at least once in the evening. The parents of more capable youngsters would perhaps elect to use the interactive approach during structured playtimes. If this alternative or another ultimately were selected (perhaps a different self-help skill), a list of appropriate devices, materials and playthings would be provided to the parent or baby sitter.

The writer was prepared to visit the families on a Saturday or Saturdays during the 2, 1-month time periods. The goal was to review the program in depth and to offer suggestions for implementation.

The Saturday option was a means of providing individualized training (designed to meet the unique needs of the entire family network). The writer was available to take phone calls from the parents who called the center, as well.

An interactive approach to communication was thought to be the most appropriate solution to the problem because it is loosely based on a number of tried and true communication strategies, such as giving the child an active choice, labeling items in the environment and turn-taking. The program is easy to follow; it doesn't require any additional materials, additional investment of time or energy. The program is flexible enough so that the parent can make modifications or amendments at any time. In addition, a restrictive group training session (restrictive in the sense that it involves the provision of a limited number of group training sessions) when highly attractive to its members provides considerable pressure on them to conform to therapeutic demands and group norms.

A show of hands would also indicate whether or not the families would adopt the 1-month program in the home (the question would be posed by the speaker at the conclusion of the workshop presentations). Group training is economical and provides an emotional support system with other parents of handicapped children. The Saturday option

was thought to insure that the child and parent would both be at home at the same time for demonstration of skills.

Report of Action Taken

This writer attended a workshop presented by Sima Gerber-Wollner which focused on the development of pragmatic intervention goals and procedures. The writer gained additional knowledge about a pragmatic approach to language development for school-aged language impaired children.

Prior to the group training sessions, informative circulars and newsletters which highlighted the purpose of the program as well as times and location (plus) a family involvement questionnaire/RSVP (attached to a cover sheet and entitled Family Involvement Sheet) were sent home with the children and collected. Mommies and Daddies received Mommygrams and Daddygrams (progress notes) which described briefly the child's progress in speech and how the parent could help the skill being taught carryover naturally to the home. Each parent was called and informed of the lunchtime meetings, a time when 90% of the parents who had previously participated in educational meetings attended. A full luncheon was offered at both meetings as well as child care and car pool services. Parents were notified in writing that a photographic display showing the youngsters doing educational tasks would be hung

in the lobby. Some of the photos, as well as a short article describing the initial meeting were sent to the local papers and served as an additional incentive for parents to come to the meeting.

Both meetings addressed the issue of an interactive approach to communication. The following points were stressed. The family members were shown how an interactive approach to communication differs from a more conventional approach to language stimulation. Those who subscribe to an interactive approach to communication feel that language and communication skills should be taught by all family members in the child's natural environment. No two houses are alike and family members differ in their abilities to generalize recommendations from another situation to their own 4 walls, furnishings, and yard. The proponents of an interactive approach to communication believe that language targets selected must be appropriate for the child's skill level and interest. The teaching episodes are incidental, brief, positive, and oriented towards communication, rather than language teaching per se. These episodes enable the handicapped youngster to "react" to his environment. Communication can be vocal or non-vocal. Incidental teaching resembles teaching that naturally occurs in mother/child dyadic interaction.

Paper and pencil was provided so that the parents could take notes. Handouts which took into consideration readability, native language and interest level of the parents were provided at the close of each session. A bibliography of materials was given to each parent. All parents received the literature regardless of their attendance at the meetings. Each parent/family member, interested person received a personal note thanking him or her for coming. The writer was available to come to the home on Saturdays to answer any questions and to help implement the program. If Saturday was not convenient, a mutually arranged date was scheduled. The PAR was sent out asking parents their opinion of educational programs at the center to date.

There was 1 month devoted primarily to circular distribution (including Mommygrams and Daddygrams which described the child's progress in speech therapy sessions and listed ways in which the skills could carry over to the home), newsletter distribution (informing parents and interested persons of the highlights of the scheduled workshops), as well as family involvement questionnaire distribution, completion and collection.

One workshop was held in the beginning of the second month and another was held in the third month.

The local newspapers were informed of the initial workshop a week and a half before it was held. It was anticipated that there would be implementation of the interactive approach to communication at mealtimes/playtimes following the workshop presentations. The speaker was available to come to the homes of those parents who participated in an aspect of the workshop and wanted to implement the program for a 1-month trial period.

During the third month, parent/family members concluded the first implementation phase and completed the PAR worksheet. Another group of parents attended the second workshop and completed the PAR thereafter. When the majority of follow-up questionnaires had been received, the data were analyzed and results were written up.

CHAPTER V

RESULTS, CONCLUSIONS AND RECOMMENDATIONS

A day training center is comprised of different families. Each family is a social system composed of people who interact with each other in various ways. The ways in which they interact with the handicapped family member and the staff members who work with the child at the center are determined in part by cultural expectations; socially structured situations and the biological and psychological characteristics of the members themselves. Cultural expectations address the family's perception of how society views a handicapped child; the issue of who should raise the child and who should be the wage earner; and the value of receiving an education. Socially structured situations refer to whether the family belongs to the dominant group or to a minority group. Physical limitations and/or emotional needs determine the biological and psychological make-ups of the family members themselves.

Thus, according to Turnbull and Turnbull (1982), the question that an educator of special education should address is "What types of families with what types of children would benefit from what particular types of involvement?" The issue of equal participation

in the raising of the handicapped child is at hand.

Results

The Family Involvement Sheet (FIS) was the preface to the workshops which were held on December 10, 1986 and February 20, 1987 and was sent out on schedule to the 46 day training families. Responses to the questionnaire and the attached RSVP were received from 20 families who indicated that at least 1 representative would be present at either meeting. This writer then used the FIS to study the family structure of the day training youngsters and came up with the following results. Six different family compositions were created. Category 1 consisted of a family composed of the natural parents and the handicapped child. Two families belonged to category 1. Category 2 consisted of the natural parents, the handicapped child and normal siblings. Nine families belonged to category 2. Category 3, of which there were 2 members, was composed of the natural parents and 2 handicapped offspring. Category 4 consisted of a single mother, the handicapped child, plus or minus normal sibs. Two families were in category 4. Category 5 consisted of foster care parents, handicapped children, plus or minus foster siblings. Two families belonged to category 5. Lastly, category 6 consisted of the extended family composed of natural parents, a relative, the handicapped child, plus

or minus normal siblings. - Three families belonged to category 6.

Participation in programming was defined as a family member and/or significant other providing caregiving, and/or physical activity, and/or educational activities to the handicapped child. Caregiving referred to bathing, dressing, feeding and toileting. Physical activity referred to playtime or recreation while educational programming referred to specific times during the day set aside for toilet training, communication, physical therapy and for increasing feeding skills.

Table 1 indicates that all mothers provided caregiving and physical activity to their handicapped youngsters, while only 40% of the fathers and 48% of the siblings provided caregiving and physical activity to the handicapped youngsters.

In the area of educational programming, approximately 90% of the families made use of teachable moments, 40% had pets who were considered "members" of the family and 75% of the families used more than 1 room of the house for programming.

Forty percent of the families set aside time for educational programming. Ninety-five percent of the families with educational programming had at least the mother doing programming. According to Table 2, 45% of the families

had only the mother providing educational programming;
 25% of the families had both the mother and father;
 25% of the families had the mother, father and siblings,
 while 5% of the families provided no educational programming
 to the handicapped member.

Table 1

Percentages of Persons Providing Caregiving and/or
Physical Activity to Child

Group	Activity		
	Caregiving	Physical	Both
Mothers	--	--	100%
Fathers	10%	15%	40%
Siblings	8%	32%	48%
Grandmothers	10%	10%	25%
Grandfathers	5%	10%	10%
Aunts	5%	5%	10%
Babysitters	10%	5%	15%
Others (friends, nurses, uncle)	--	15%	10%

Table 2

Percentages of Persons Providing Educational Programming
to Child

Group	% of persons providing educational programming to child in home environment
Mothers only	45%
Mothers and fathers	25%
Mothers, fathers, and sibs	25%
Total	95%

Note. Five percent of the families provided no
educational programming at all.

Parents seemed to realize that communication is not language teaching but is an ongoing, spontaneous process. However, 55% of the caregivers (see Table 3) used full sentences when conversing with their handicapped family members. Although the majority of the youngsters at the center are pre-pubescent/adolescents, mentally they are functioning as infants and toddlers. When a parent labels items that are in the child's environment, this task can be as simple as using 1 word or 1 gesture at different times during the day. This point was addressed and clarified for those in attendance.

Two meetings were scheduled to encourage optimal parental participation. The second meeting originally scheduled for February 10, 1987 was postponed to February 20, 1987 due to a snowstorm. Parents were informed of the meetings in a number of different ways. All parents received personal telephone calls; when parents met with staff members they were told of the meetings, and when this writer was present at an IEP conference, the goals of the workshop were discussed in depth.

Twenty family members in total were in attendance at both workshops. There was 1 male member in attendance at the second meeting, in addition to 2 young siblings.

Table 3

Language Used by Caregivers to Communicate with the Special Child, By Percentages

Type of language (chatter patterns)	Percentages of caregivers who use specific language forms
Full sentences	55%
Full sentences, 2-word phrases	5%
Full sentences, 2-word phrases, and single words	10%
2-word phrases	10%
Full sentences, single words	5%
Full sentences, baby talk	5%
Single word utterances	5%

All 46 families received information about an interactive approach to communication via a newsletter and/or workshop presentation. Materials were available in English and Spanish and a center translator (a new member of the day training staff) was present at the second meeting. Three parents took advantage of home visitations. One parent who was not able to attend either meeting expressed her interest in the program after receiving the literature in the mail, and a home visitation was scheduled.

At the end of the workshop, the Parents as Resources worksheet (PAR) was given to those parents who attended either meeting and was sent out to the remainder of the day training families. Sixteen PARs were returned and the following results were obtained. According to Table 4, parents benefited (moderately or very much) from the following forms of communication. Forty-eight percent benefited from the newsletter which was sent out, 73% benefited from personal telephone calls from this speech-language pathologist. Fifty-four percent benefited from individual conferences with staff members; 60% benefited from afternoon meetings; and 47% benefited

Table 4

School/Home Forms of Communication Deemed Beneficial
to Caregivers of Severely and Profoundly Retarded Children^a

Type of communication offered by day training facility	No. of caregivers who've benefited from a particular type of communication	% of caregivers found in each communication category
Newsletter	8	48%
Telephone calls	12	73%
Daily contact with staff	5	34%
Individual conferences	9	54%
Workshops	9	53%
Classroom observations	10	60%
Observation of speech techniques	2	13%
Afternoon meetings	10	60%
Evening meetings	7	47%
Progress notes (Mommygrams and Daddygrams)	7	47%
Home visits (by speech-language pathologist)	2	13%

^aResults obtained by looking at completed PARs.

Note. Although home visits and demonstration of speech techniques are offered to the day training families, most have not taken advantage of these opportunities to date.

from progress notes (Mommygrams and Daddygrams) being sent out. Forty-eight percent of the parents wanted to see more meetings next year while 39% were happy with the amount of meetings scheduled. Finally 67% of the parents who responded felt that more parents ought to be more involved with project activities. Most of the families that responded to the PAR did not request this writer to visit the home or have the opportunity to observe speech techniques to date, hence the lower percentages obtained in those 2 areas.

To reiterate, according to the literature, parents of handicapped children play 3 key roles: parent as parent/caregiver; parent as decision maker/advocate and/or parent as change-agent teacher. Day training parents experience, in addition to the trials and tribulations of everyday life, the trials and tribulations of living with the 24 hour child. One cannot truthfully expect parents to attend workshops or schedule home visitations if their children pass away unexpectedly (there were 3 deaths in a 4 month time period); or if they must work 2 jobs to put food on the table; or if they move away to seek better employment opportunities; or if their children

are hospitalized, or if they themselves are hospitalized. The list is never ending.

If one adds the fourth key role, parent as learner, then all of the objectives of this practicum were attained. Each parent received the literature and hopefully gained something from it. In time, the parent as parent/caregiver may change to parent as change-agent/teacher. There is a need for sequential growth and change over a period of time with family member involvement.

Conclusions

An interactive approach to communication enables professionals and parents to be involved in the severely handicapped student's education in an optimal manner. The program consists of realistic curriculum goals that are functional for the child. Each child is provided with an individualized curriculum designed to meet his unique learning style and needs. In addition, differences in cultures, life styles, and value systems of parents are incorporated into the curriculum since parents ultimately determine what and how their children should be taught. When instruction occurs in the home, fathers, siblings and extended family involvement can become a realistic and obtainable goal (Villani, 1980). How a professional conducts himself, how he gets his point across, how he explains the purposes of his program may be the difference between parental cooperation and parental distrust. Professional mishandling of parents of disabled youngsters can often be more detrimental to the parents than the youngsters' disabilities themselves. If parent-child interactions can be altered in the desired direction, not only will the child learn more from the parent, but critical interactional patterns will improve. The hope is that once parent-child interactions are altered

along specific dimensions as a result of training, that behavior will endure across time and generalize naturally to other interactive situations.

An unanticipated outcome of the practicum was the enthusiasm generated by the center staff members towards the Project Feedback Communication List. This practicum was shared with the day training faculty at an inservice program in March. Staff members indicated that they would be willing to use the PFCL in the classroom and felt that it could effectively serve as an informal assessment tool.

The staff members and at least 20 family members understand that language/communication skills may be integrated as target objectives of routine activities and non-language lessons which occur throughout the day. Further, at least 20 family members are willing to explain this concept and others to their loved ones. At least 20 family members recognize the role of the speech-language pathologist in a day training center and have refined their observational skills in order to identify the modes of communication utilized by their handicapped daughter, son, brother, sister, grandchild, niece, nephew, etc. By identifying said modes of communication, they have now been and will continue being able to

help the day training staff members formulate more realistic educational goals and objectives at the IEP conferences. Eighty-seven percent of the parents believe that parent meetings are a viable and necessary part of day training, and 67% believe that parents ought to become more involved with project activities.

These results are encouraging. The direction is optimistic and positive, and the children at this facility should ultimately profit.

Recommendations

This program is suitable for those who work in similar facilities and for those who work with developmentally delayed youngsters in preschools and in clinics. Those who foresee implementing this type of program should be familiar with the stages of normal language development and with those prelinguistic/paralinguistic skills which are the precursors to the spoken word. Further, the PFCL should become a part of the student's permanent records at the facility. It should be used by the parents and staff members to assess the child's communicative abilities at the intake process and also at IEP times. A workshop presented for the non-disabled siblings on an interactive approach to communication would be an effective way of furthering this solution at the day training facility.

Dissemination

A bill was recently introduced in the Senate that would provide funds to schools for programs aimed at giving parents broader input into public education. The bill would allow funding for demonstration projects, such as parent training programs; hiring, training and using educational personnel to oversee parental activities, and to provide educational materials to be distributed to parents.

The writer will contact those in charge of the bill, and ultimately, the Project Feedback program will be presented and utilized by parents and personnel around the state.

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APPENDIX A
FAMILY INVOLVEMENT SHEET

FAMILY INVOLVEMENT SHEET

1. NAME _____
2. NUMBER OF PERSONS LIVING IN THE HOUSEHOLD _____
3. CIRCLE THE ANSWERS THAT APPLY. MY FAMILY CONSISTS
 OF: MOTHER FATHER OTHER CHILDREN: Specify
 ages and sex _____

 GRANDMOTHER GRANDFATHER AUNT
 UNCLE BABYSITTER OTHER _____

4. Circle the persons who provide direct care to your child. Specify whether it is in the area of caregiving (bathing, dressing, feeding, diapering), physical activity (playtime, recreation) or both.
- | | | |
|---|------------|-------------------|
| A. MOTHER | CAREGIVING | PHYSICAL ACTIVITY |
| E. FATHER | CAREGIVING | PHYSICAL ACTIVITY |
| C. OTHER CHILDREN | CAREGIVING | PHYSICAL ACTIVITY |
| HOW MANY OF THE OTHER CHILDREN PARTICIPATE? _____ | | |
| D. GRANDMOTHER | CAREGIVING | PHYSICAL ACTIVITY |
| E. GRANDFATHER | CAREGIVING | PHYSICAL ACTIVITY |
| F. AUNT | CAREGIVING | PHYSICAL ACTIVITY |
| G. BABYSITTER | CAREGIVING | PHYSICAL ACTIVITY |
| H. OTHER | CAREGIVING | PHYSICAL ACTIVITY |

please specify
relationship

5. Do you set aside specific times during the day for educational programming (toilet training, increase feeding skills, physical therapy, communication: reads to or shows child pictures in storybook, sings to or plays music for child, labels things in environment)?

YES

NO

6. Who in the household provides educational programming?

MOTHER

FATHER

OTHER CHILDREN
(How many?) _____

GRANDMOTHER

GRANDFATHER

AUNT

UNCLE

BABYSITTER

OTHER _____

7. Do you own a pet? Please specify _____

8. Where do you conduct programming?

living room

dining room

kitchen

bedroom

backyard

bathroom

den

other _____

9. Do you make use of teachable moments? Teachable moments are unplanned times during the day which are used to instruct the child.

YES

NO

10. When you communicate with your child, what type of language do you use?

A. I speak in full sentences.

B. I speak in two-word phrases.

C. I use 1 word at a time.

D. I speak in "baby talk."

E. I use sign language and natural gestures.

El 10 de noviembre de 1986

Estimados Padres,

Adjunto encontrarán los formularios de una encuesta sobre sus familias. Esta encuesta será utilizada en la reunion del 10 de diciembre, la cual yo estoy acargo. Ustedes están invitados a esta reunion, si no es posible asistir, favor de llenar el formulario y devolverlo con su hijo/a. La majoria de las preguntas consiste en circular la mejor repuesta o en completar el blanco con una palabra. Espero que no tengan dificultad en completar estas hojas para el 22 de noviembre.

Si ustedes desean añadir mas información a estas hojas, favor de hacerlo. Todo esta información es estrictamente confidencial. Muchas gracias.

Atentamente,

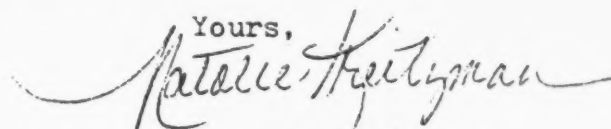
Natalie Kreitzman
Terapista de Habla

November 10, 1986

Dear Parents,

I have provided you with a copy of the Family Involvement Sheet. The Family Involvement Sheet will be used at the December 10th workshop which I will conduct. I am hoping that your family and friends will join us at the luncheon workshop which will begin approximately at 11:00 in the morning. Even if you don't anticipate attending at this time (please feel free to drop in at the last minute), be kind enough to complete the form and return it with your child. Most of the questions involve circling the best answer or filling in 1 word. I hope that you will not have any difficulty completing the form by the 22nd of November. Thank you.

Yours,



Natalie Kreitzman
Speech Therapist

PS

Should you wish to add any additional information to the form, please do so.

PPSS

All information is strictly confidential.

APPENDIX B
PROJECT FEEDBACK WORKSHEETS

INSTRUCTIONS FOR PROJECT FEEDBACK WORKSHEETS

Key Terms Explained:

Vocalizations: vowel-like sounds, grunts, groans, moans, raspberries

Babble: syllables which repeat consisting of both vowels and consonants, ga-ga.

Word approximation: "nana" for banana

Word combinations: 2 or 3 related words, for example:

agent and action: Billy fall

action and object: Put cup

agent and object: Billy cup

Eye contact: communicators look directly at each other's face
(eyes appear to meet)

Positive: movement of body, head, limbs, or trunk towards partner, physical contact (arm around partner, kissing, hugging, bouncing, nuzzling).

Negative: movements away from caregiver, hits, kicks, grabs, bites (self or another) pulls caregiver's hair (this may be positive if caregiver feels it is a method of getting attention from another), throws objects away.

Action: tugs caregiver's clothing, uses another's hand as a social tool (uses caregiver's hand to restart an activity), gives object on request or voluntarily, touches object

Demonstration: pointing or glancing at object or person

Gesture: sign, shaking head (refusal or saying yes), waves hand, lifts hands up.

Please feel free to use one or both worksheets.

If worksheets are used, please indicate the person who is providing the information at the time (for your own record) Mom, Dad, brother, etc.

If child performs task more than 1 time in a 10 minute period, please feel free to place the number of times in the box. Otherwise, a simple check is acceptable.

1. Use worksheet during play or at mealtimes.
2. Use teaching sheet if you are teaching a skill.
3. Please try making use of teachable moments.
4. Use worksheet for a 10 minute period of time.
5. Try to use worksheet for the 30 day period.
6. Please bring worksheet with you to IEP meetings. Feel free to call me if you would like to share information about the worksheet.

UNRESPONSIVE

ACTION

(pointing/glancing)

DEMONSTRATION

GESTURE

Negative --

Positive

Drooling

Frowning

Smiling.

Eye-contact

word combinations

Agent-object
Agent-action

Agent-action

SINGLE WORD

NONSENSE SPEECH

WORD
Approximations-

Approximations

Babbling

Vocalizations

Laughing

Screaming

crying

whimpering/

whining.

ate

104

128

APPENDIX C
PARENTS AS RESOURCES (PAR)

PARENT INVOLVEMENT Please circle the most appropriate responses.

1. Parent meetings:

too few enough too many

2. I benefited from the following school/home forms of communication:

- | | | | | |
|--|------------|------------|-----------|-------------|
| a. Newsletter | not at all | moderately | very much | no response |
| b. Telephone calls | not at all | moderately | very much | no response |
| c. Daily contact with staff | not at all | moderately | very much | no response |
| d. Individual conferences with staff | not at all | moderately | very much | no response |
| e. Workshops | not at all | moderately | very much | no response |
| f. Classroom observations | not at all | moderately | very much | no response |
| g. Observation of speech therapy/feeding therapy | not at all | moderately | very much | no response |
| h. Afternoon meetings | not at all | moderately | very much | no response |
| i. Evening meetings | not at all | moderately | very much | no response |
| j. Progress notes | not at all | moderately | very much | no response |
| k. home visits | not at all | moderately | very much | no response |

3. Next year I would like to see:

more meetings less meetings same amount

4. In relation to project activities (newsletter, speaking with parents of prospective children), parents ought to be:

less involved same involvement more involved

5. Suggestions for future meetings and other forms of parent involvement:

Home Visits (by therapist with family)
 Augmentative Communication/Communication Boards
 Further explanation of the IEP Conference
 The Implementation of a toy library
 Feeding Therapy

OTHER _____